SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
Company Tracking Number:	*CLDEN 09*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Constitution Life Insurance Company

Product Name: Sr. Dental	SERFF Tr Num: UNAM-126216304	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 43153
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: CLDEN 09	State Status: FEES PAID
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Mary Reichert	Disposition Date: 08/17/2009
	Date Submitted: 08/07/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/17/2009	Explanation for Other Group Market Type:
	State Status Changed: 08/07/2009
Deemer Date:	Created By: Mary Reichert
Submitted By: Mary Reichert	Corresponding Filing Tracking Number:

Filing Description:

We are submitting the above referenced forms for your review and approval. We are submitting the exact same forms for our sister company, Pennsylvania Life Insurance Company, under SERFF # UNAM 126216305.

This is a dental policy form designed to cover dental services specifically for senior citizens. Deductibles and co-payments apply as well as waiting periods from the effective date of coverage, ranging from zero days for routine exams to 24 months for periodontal surgery. Persons age 63 and over are eligible for insurance as the Primary Insured person. Spouses are eligible regardless of age.

The policy is guaranteed issue and guaranteed renewable subject to premium changes by class, based on issue state.

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
Company Tracking Number:	*CLDEN 09*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

There are two levels of coverage available, Enhanced Benefit and Standard Benefit. Each level has area factors for services, based on zip code. This information is shown in the Actuarial Justification enclosed.

A List of Covered Dental Services and Schedule of Benefits will be inserted in the policy at time of issue according to which benefit plan, Enhanced or Standard, is chosen by the Insured. In the List of Covered Dental Services, the Maximum Expense amounts have been bracketed. The toll free number on the Schedule of Benefits page has also been bracketed.

We expect to offer these plans in a variety of ways: via face-to-face with the agent and applicant, via telephone with licensed agents completing the application form, and potentially through the use of web-based application completion.

To the best of my knowledge and belief, these forms are in compliance with the laws and regulations of your state, and do not contain anything that has been previously objected to by your department.

Company and Contact

Filing Contact Information

Mary Reichert,
P.O. Box 958465
Lake Mary, FL 32795-8465

mreichert@universalamerican.com
407-995-8000 [Phone] 8355 [Ext]

Filing Company Information

Constitution Life Insurance Company
1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
(407) 995-8000 ext. [Phone]

CoCode: 62359
Group Code: 953
Group Name:
FEIN Number: 36-1824600

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50 forms + $50 rates +$100
Per Company:	No

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Constitution Life Insurance Company	$100.00	08/07/2009	29695552

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/17/2009	08/17/2009

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/17/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
Company Tracking Number:	*CLDEN 09*		
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Senior Dental Insurance Policy	Approved-Closed	Yes
Form	Outline of Coverage - $0 deductible	Approved-Closed	Yes
Form	Outline of Coverage - $50 deductible	Approved-Closed	Yes
Form	Application - $0 deductible	Approved-Closed	Yes
Form	Application - $50 deductible	Approved-Closed	Yes

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
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Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/17/2009	CLDEN 09 AR	Policy/Contract/Fraternal Certificate	Senior Dental Insurance Policy	Initial		46.800	CLDEN 09 AR policy.pdf
Approved-Closed 08/17/2009	CLDEN1 09 OC AR	Outline of Coverage	Outline of Coverage - $0 deductible	Initial		40.300	CLDEN1 09 OC AR.pdf
Approved-Closed 08/17/2009	CLDEN2 09 OC AR	Outline of Coverage	Outline of Coverage - $50 deductible	Initial		40.300	CLDEN2 09 OC AR.pdf
Approved-Closed 08/17/2009	CLDENAPP1 09 AR	Application/Enrollment Form	Application - $0 deductible	Initial		45.600	CLDENAPP1 09 AR.pdf
Approved-Closed 08/17/2009	CLDENAPP2 09 AR	Application/Enrollment Form	Application - $50 deductible	Initial		45.600	CLDENAPP2 09 AR.pdf

CONSTITUTION LIFE INSURANCE COMPANY

HOME OFFICE: Houston, Texas
ADMINISTRATIVE OFFICE:
PO Box 13667; Pensacola, FL 32591-3667
(866) 216-5844

LIMITED BENEFIT HEALTH INSURANCE COVERAGE
DENTAL INSURANCE POLICY

Notice to Buyer: This is a Limited Benefit Dental Insurance Policy. Benefits are supplemental and are not intended to cover all medical expenses.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

This policy provides benefits for Covered Dental Expenses only. Benefits are subject to the definitions, provisions, exclusions and limitations of this policy. The policy is guaranteed renewable during the lifetime of the Insured. We reserve the right to change premium rates on a class basis.

THIRTY (30) DAY RIGHT TO EXAMINE AND RETURN YOUR POLICY

Please read your policy carefully. If, for any reason, you are not satisfied, you can return this policy to us within 30 days of receiving it. If returned, the policy will be void from its beginning, and any premium you paid will be refunded.

In this policy, "you" and "your" refer to the Insured named on the Policy Schedule on Page 3, and in the application. Your "covered spouse" will be the person named as the spouse on your application. The terms "we," "our," and "us" refer to Constitution Life Insurance Company.

WE RESERVE THE RIGHT TO CHANGE PREMIUM RATES

You have the right to continue this policy in force by the timely payment of renewal premiums. If you continue the policy, we will not place restrictions on it or terminate it. We can change the premiums for policies of this form issued to persons in the same insurance class in your state. Any premium changes we make will be on a premium due date. You will receive written notice of any premium change before the change, as provided by the laws of your state. The notice will be sent to your address as shown in our records.

Signed on the Effective Date by:

Secretary

President

LIMITED BENEFIT DENTAL INSURANCE POLICY
THIS POLICY CONTAINS A DEDUCTIBLE PROVISION

Table of Contents

Page

Schedule of Benefits
Standard Benefit Plan
CLDEN 09

Policy Number:	Effective Date:
Primary Insured:	Policy Anniversary Date:
Insured Spouse:	Area:
Premium Due Date:	Premium Mode:

I. Annual Deductible, Applies to Types I, II, III and IV Services
Per Person, per Policy Year [$0] [$50]

II. Annual Maximum Applicable to Covered Dental Expenses
Maximum Amount per Person per Policy Year $1,500

III. Waiting Periods – From each Insured Person's Effective Date.

Type I Services:	None
Type II Services:	6 Months
Type III Services:	12 Months
Type IV Services:	18 Months

IV. Type I Services – Routine exam; prophylaxis

Type II Services – Other X-rays; fillings; simple extractions; palliative treatment Biopsies; histopathologic examinations; repairs to existing crowns, dentures and bridges; recementation of existing crowns, inlays, onlays and bridges; therapeutic drug injections

Type III Services – Endodontics (root canals); non-surgical periodontics (gum treatment); surgical extractions; extraction of impacted teeth; other oral surgery; general anesthesia and IV sedation; denture relines and rebases; denture adjustments

Type IV Services - Periodontal Surgery; inlays and onlays; crowns; complete and partial dentures; fixed bridgework

V. Frequency Limits - **Refer to Policy – Exclusions and Limitations**

Exams	1 time per 6 months
Cleaning	1 time per 6 months
Bitewing X-rays	1 time per 12 months
Full Mouth X-rays	1 time per 60 months

Fillings	1 time per tooth surface per 24 months
Root canals	1 time per 36 months per tooth
Periodontal Surgery	1 time per 36 months per quadrant
Root Planing	1 time per 24 months per quadrant
Crowns, Inlays, Onlays	1 time per tooth per 7 years
Bridgework	1 time per area per 7 years
Full and Partial Dentures	1 time per arch per 5 years

For verification of benefits and claim filing information, call [800-443-1565].

Mail claims to: Constitution Life Insurance Company
Dental Department
P.O. Box 13667
Pensacola, Florida 32591

Schedule of Benefits
Enhanced Benefit Plan
CLDEN 09

Policy Number:	Effective Date:
Primary Insured:	Policy Anniversary Date:
Insured Spouse:	Area:
Premium Due Date:	Premium Mode:

I. Annual Deductible, Applies to Types I, II, III and IV Services
Per Person, per Policy Year [$0] [$50]

II. Annual Maximum Applicable to Covered Dental Expenses
Maximum Amount per Person per Policy Year $6,000

III. Waiting Periods – From each Insured Person's Effective Date.

Type I Services:	None
Type II Services:	6 Months
Type III Services:	12 Months
Type IV Services:	18 Months

IV. Type I Services – Routine exam; prophylaxis

Type II Services – Other X-rays; fillings; simple extractions; palliative treatment Biopsies; histopathologic examinations; repairs to existing crowns, dentures and bridges; recementation of existing crowns, inlays, onlays and bridges; therapeutic drug injections

Type III Services – Endodontics (root canals); non-surgical periodontics (gum treatment); surgical extractions; extraction of impacted teeth; other oral surgery; general anesthesia and IV sedation; denture relines and rebases; denture adjustments

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Root Planing	1 time per 24 months per quadrant
Crowns, Inlays, Onlays	1 time per tooth per 7 years
Bridgework	1 time per area per 7 years
Full and Partial Dentures	1 time per arch per 5 years

For verification of benefits and claim filing information, call [800-443-1565].

Mail claims to: Constitution Life Insurance Company
Dental Department
P.O. Box 13667
Pensacola, Florida 32591

LIST OF COVERED DENTAL SERVICES - STANDARD PLAN

The following is a complete list of those dental services which will be considered for payment by the Company after the expiration of any applicable waiting period. These services must be started while insured and completed while insured or during the extension of benefits period, if any.

No payment will be made for any expense or for any service not included in the list if covered dental services or included in the list of exclusions.

Type I Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
0120	Periodic Oral Evaluation	[$13]	[$17]	[$21]
0150	Comprehensive Oral Evaluation	[$18]	[$24]	[$30]
0120, 0150 – Limited to one time in any 6 consecutive month period.				
1110	Prophylaxis - Adult	[$27]	[$36]	[$45]
1110 – Limited to one time in any 180 consecutive day period. This frequency limit is combined with the 180 day frequency limit for periodontal maintenance (code 4910). Only one occurrence of either procedure is payable in any 180 consecutive day period.				

Type II Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
0210	Intraoral - Complete Series (inc bitewings)	[$30]	[$40]	[$50]
0330	Panoramic Film	[$25]	[$33]	[$41]
0210, 0330 – Limited to one time in any 60 consecutive month period. For benefit determination purposes, a full mouth series will be deemed to include bitewings and 10 or more periapical x-rays.				
0220	Intraoral - Periapical - First Film	[$5]	[$7]	[$9]
0230	Intraoral - Periapical - Each Addl Film	[$3]	[$3]	[$4]
0220-0230 – A maximum of 4 periapical x-rays are payable per 12 month period.				
0240	Intraoral - Occlusal Film	[$8]	[$11]	[$14]
0240 – Limited to two films in any 12 consecutive month period.				
0270	Bitewing - Single Film	[$6]	[$7]	[$9]
0272	Bitewings - Two Films	[$9]	[$12]	[$15]
0274	Bitewings - Four Films	[$14]	[$18]	[$23]
0270-0274 – Limited to one set in any 12 consecutive month period. Reimbursement will be limited to a maximum of 4 films per occurrence.				
2140	Amalgam - One Surface	[$28]	[$37]	[$46]
2150	Amalgam - Two Surfaces	[$35]	[$46]	[$58]
2160	Amalgam - Three Surfaces	[$42]	[$56]	[$70]
2161	Amalgam - Four or More Surfaces	[$50]	[$66]	[$83]
2140-2161 – Multiple restorations on one surface will be paid as a single filling. Benefits for the replacement of an existing amalgam restoration are only payable if at least 24 months have passed since the existing amalgam was placed.				
2330	Resin-based Composite - One Surface, Anterior	[$33]	[$44]	[$55]
2331	Resin-based Composite - Two Surfaces, Anterior	[$41]	[$54]	[$68]
2332	Resin-based Composite - Three Surfaces, Anterior	[$49]	[$65]	[$81]
2335	Resin-based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	[$56]	[$75]	[$94]
2391	Resin-based Composite - One Surface, Posterior	[$28]	[$37]	[$46]
2392	Resin-based Composite - Two Surfaces, Posterior	[$35]	[$46]	[$58]
2393	Resin-based Composite - Three Surfaces, Posterior	[$42]	[$56]	[$70]
2394	Resin-based Composite - Four or More Surfaces, Posterior	[$50]	[$66]	[$83]
2330-2394 – Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations. Benefits for the replacement of an existing composite resin restoration are only payable if at least 24 months have passed since the existing filling was placed. Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.				

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
7140	SIMPLE EXTRACTION Root Removal - Exposed Roots	[$34]	[$45]	[$56]
7140 – The benefit includes an allowance for local anesthesia and routine post-operative care.				
9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	[$19]	[$25]	[$31]
9110 – Paid as a separate benefit only if no other service is rendered during the visit except x-rays.				
0415	Bacteriologic Studies for Determination of Pathologic Agents	[$28]	[$37]	[$46]
0415 – Only payable in conjunction with a covered biopsy procedure (codes 7285, 7286).				
5410	Adjust Complete Denture - Maxillary	[$18]	[$24]	[$30]
5411	Adjust Complete Denture - Mandibular	[$18]	[$24]	[$30]
5421	Adjust Partial Denture - Maxillary	[$18]	[$24]	[$30]
5422	Adjust Partial Denture - Mandibular	[$18]	[$24]	[$30]
5410-5422 – Only covered one time in any 12 consecutive month period, and only if performed more than 12 months after the initial insertion of the denture.				
5510	Repair Broken Complete Denture Base	[$35]	[$46]	[$58]
5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	[$31]	[$41]	[$52]
5610	Repair Resin Denture Base	[$38]	[$51]	[$63]
5620	Repair Cast Framework	[$41]	[$55]	[$69]
5630	Repair or Replace Broken Clasp	[$41]	[$55]	[$69]
5640	Replace Broken Teeth - Per Tooth	[$35]	[$46]	[$58]
5650	Add Tooth to Existing Partial Denture	[$41]	[$55]	[$69]
5660	Add Clasp to Existing Partial Denture	[$48]	[$64]	[$81]
5510-5660 – Limited to repairs performed more than 12 months after initial insertion of the denture and then not more frequently than once per denture in any 12 consecutive month period.				
2910	Recement Inlay	[$21]	[$28]	[$35]
2920	Recement Crown	[$21]	[$28]	[$35]
2910-2920 – Payable only when performed more than 12 months after initial insertion.				
6930	Recement Fixed Partial Denture	[$31]	[$41]	[$52]
6930 – Payable only when performed more than 12 months after initial insertion of the denture.				
7285	Biopsy of Oral Tissue - Hard (Bone,Tooth)	[$138]	[$184]	[$230]
7286	Biopsy of Oral Tissue - Soft (All Others)	[$86]	[$115]	[$144]
7285-7286 – The benefit includes an allowance for local anesthesia and routine post-operative care.				

Type III Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
3310	Anterior (Excluding Final Restoration)	[$110]	[$145]	[$180]
3320	Bicuspid (Excluding Final Restoration)	[$130]	[$175]	[$220]
3330	Molar (Excluding Final Restoration)	[$150]	[$200]	[$250]
3310-3330 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.				
3346	Retreatment of Previous Root Canal Therapy - Anterior	[$110]	[$145]	[$180]
3347	Retreatment of Previous Root Canal Therapy - Bicuspid	[$130]	[$175]	[$220]
3348	Retreatment of Previous Root Canal Therapy - Molar	[$150]	[$200]	[$250]
3346-3348 – Subject to review by our dental consultant. Only payable if the original root canal procedure was performed at least 36 months earlier.				
3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Ro Resorption, etc.)	[$32]	[$43]	[$54]
3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repa of Perforations, Root Resorption, etc.)	[$22]	[$29]	[$36]
3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apic Closure/Calcific Repair of Perforations, Root Resorption, etc.)	[$86]	[$115]	[$144]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
3410	Apicoectomy/Periradicular Surgery - Anterior	[$75]	[$101]	[$126]
3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	[$97]	[$129]	[$162]
3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	[$108]	[$144]	[$180]
3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	[$32]	[$43]	[$54]
3351-3426 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.				
3430	Retrograde Filling - Per Root	[$26]	[$35]	[$43]
3430 – Includes all pre-operative, operative and post-operative x-rays, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.				
3450	Root Amputation - Per Root	[$65]	[$86]	[$108]
3920	Hemisection (Including Any Root Removal), Not Incl. Root Canal Therapy	[$52]	[$69]	[$86]
3450-3920 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.				
5710	Rebase Complete Maxillary Denture	[$75]	[$100]	[$125]
5711	Rebase Complete Mandibular Denture	[$75]	[$100]	[$125]
5720	Rebase Maxillary Partial Denture	[$75]	[$100]	[$125]
5721	Rebase Mandibular Partial Denture	[$75]	[$100]	[$125]
5730	Reline Complete Maxillary Denture (Chairside)	[$39]	[$52]	[$65]
5731	Reline Complete Mandibular Denture (Chairside)	[$39]	[$52]	[$65]
5740	Reline Maxillary Partial Denture (Chairside)	[$39]	[$52]	[$65]
5741	Reline Mandibular Partial Denture (Chairside)	[$39]	[$52]	[$65]
5750	Reline Complete Maxillary Denture (Laboratory)	[$52]	[$69]	[$86]
5751	Reline Complete Mandibular Denture (Laboratory)	[$52]	[$69]	[$86]
5760	Reline Maxillary Partial Denture (Laboratory)	[$52]	[$69]	[$86]
5761	Reline Mandibular Partial Denture (Laboratory)	[$52]	[$69]	[$86]
5710-5761 – Limited to relining or rebasing done more than 12 months after the initial insertion, and then not more than one time per denture in any 36 consecutive month period.				
5850	Tissue Conditioning, Maxillary	[$17]	[$23]	[$29]
5851	Tissue Conditioning, Mandibular	[$17]	[$23]	[$29]
5850-5851 – Payable only if at least 12 months have elapsed since the insertion of a full or partial denture and only once in any 36 consecutive month period.				
4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant	[$30]	[$40]	[$50]
4342	Periodontal Scaling and Root Planing – One to Three Teeth Per Quadrant	[$13]	[$17]	[$22]
4341-4342 – Limited to one time per quadrant of the mouth in any 24 consecutive month period. Not separately payable if performed on the same treatment plan as prophylaxis.				
4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	[$17]	[$23]	[$29]
4355 – Payable once per patient per lifetime. Not payable if performed on same date as prophylaxis (code 1110).				
4910	Periodontal Maintenance	[$18]	[$24]	[$30]
4910 – Payable only if at least 6 months have passed since the completion of active periodontal surgery and only one time thereafter in any 6 consecutive month period. Not payable if performed within 6 months of a prophylaxis (code 1110). The benefit for this procedure includes an allowance for an exam and scaling and root planing.				
7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal Bone and/or Section of Tooth	[$38]	[$50]	[$63]
7220	Removal of Impacted Tooth - Soft Tissue	[$45]	[$60]	[$75]
7230	Removal of Impacted Tooth - Partially Bony	[$56]	[$75]	[$94]
7240	Removal of Impacted Tooth - Completely Bony	[$68]	[$90]	[$113]
7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	[$83]	[$110]	[$138]
7250	Surgical Removal of Residual Tooth Roots (cutting Procedure)	[$26]	[$35]	[$43]
7310	Alveoloplasty in Conjunction with Extractions - Per Quadrant	[$35]	[$46]	[$58]
7320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	[$75]	[$101]	[$126]
7471	Removal of Lateral Exostosis (Maxilla or Mandible)	[$65]	[$86]	[$108]
7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	[$32]	[$43]	[$54]
7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	[$32]	[$43]	[$54]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	[$69]	[$92]	[$115]
7970	Excision of Hyperplastic Tissue - Per Arch	[$60]	[$81]	[$101]
7971	Excision of Pericoronal Gingiva	[$26]	[$35]	[$43]
7210-7971 – The benefit includes an allowance for local anesthesia and routine post-operative care.				
9220	General Anesthesia - First 30 Minutes	[$43]	[$58]	[$72]
9221	General Anesthesia - Each Additional 15 Minutes	[$17]	[$23]	[$29]
9241	Intravenous Sedation – First 30 Min	[$35]	[$46]	[$58]
9242	Intravenous Sedation – Ea Add 15 Min	[$11]	[$14]	[$18]
9220-9241 – Paid as a separate benefit only when necessary, as determined by us, and when administered in conjunction with complex oral surgical procedures which are covered under the policy.				
9940	Occlusal Guard, By Report	[$75]	[$101]	[$126]
9940 – Limited to one appliance in any 24 consecutive month period.				
9951	Occlusal Adjustment, Limited	[$15]	[$20]	[$25]
9952	Occlusal Adjustment, Complete	[$54]	[$72]	[$90]
9951-9952 – Payable once in any 36 month period.				

Type IV Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
2520	Inlay - Metallic - Two Surfaces	[$129]	[$173]	[$216]
2530	Inlay - Metallic - Three or More Surfaces	[$162]	[$216]	[$270]
2542	Onlay - Metallic - Two Surfaces	[$129]	[$173]	[$216]
2543	Onlay - Metallic - Three Surfaces	[$162]	[$216]	[$270]
2544	Onlay - Metallic - Four or More Surfaces	[$173]	[$230]	[$288]
2620	Inlay - Porcelain/ceramic - Two Surfaces	[$129]	[$173]	[$216]
2630	Inlay - Porcelain/ceramic - Three or More Surfaces	[$162]	[$216]	[$270]
2642	Onlay - Porcelain/ceramic - Two Surfaces	[$129]	[$173]	[$216]
2643	Onlay - Porcelain/ceramic - Three Surfaces	[$162]	[$216]	[$270]
2644	Onlay - Porcelain/ceramic - Four or More Surfaces	[$173]	[$230]	[$288]
2651	Inlay - Composite-Resin - Two Surfaces (Laboratory Processed)	[$129]	[$173]	[$216]
2652	Inlay - Composite-Resin - Three or More Surfaces (Laboratory Processed)	[$162]	[$216]	[$270]
2662	Onlay - Composite-Resin - Two Surfaces (Laboratory Processed)	[$129]	[$173]	[$216]
2663	Onlay - Composite-Resin - Three Surfaces (Laboratory Processed)	[$162]	[$216]	[$270]
2664	Onlay - Composite-Resin - Four or More Surfaces (Laboratory Processed)	[$173]	[$230]	[$288]
2520-2664 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit includes an allowance for any filling paid on the same tooth during the 90 day period preceding the preparation date of the inlay or onlay.				
2720	Crown - Resin with High Noble Metal	[$130]	[$173]	[$216]
2721	Crown - Resin w/ Predominantly Base Metal	[$129]	[$173]	[$216]
2722	Crown - Resin with Noble Metal	[$129]	[$173]	[$216]
2740	Crown - Porcelain/ceramic Substrate	[$150]	[$200]	[$250]
2750	Crown - Porcelain Fused to High Noble Metal	[$173]	[$230]	[$288]
2751	Crown - Porcelain Fused to Predominantly Base Metal	[$150]	[$200]	[$250]
2752	Crown - Porcelain Fused to Noble Metal	[$150]	[$200]	[$250]
2780	Crown – ¾ Cast High Noble Metal	[$150]	[$200]	[$250]
2781	Crown – ¾ Cast Predominantly Base Metal	[$150]	[$200]	[$250]
2782	Crown – ¾ Cast Noble Metal	[$150]	[$200]	[$250]
2790	Crown - Full Cast High Noble Metal	[$150]	[$200]	[$250]
2791	Crown - Full Cast Predominantly Base Metal	[$150]	[$200]	[$250]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
2792	Crown - Full Cast Noble Metal	[$150]	[$200]	[$250]
2720-2792 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit for a crown includes an allowance for any filling paid on the same tooth in the 90 day period preceding the preparation date of the crown.				
2950	Core Buildup, including any Pins	[$30]	[$40]	[$50]
2950 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the crown, inlay or onlay on the same tooth is covered. Includes all pins and/or prefabricated posts.				
2952	Cast Post and Core in Addition to Crown	[$45]	[$60]	[$75]
2954	Prefabricated Post and Core in Addition to Crown	[$45]	[$60]	[$75]
2952-2954 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the crown, inlay or onlay on the same tooth is covered.				
2960	Labial Veneer (Resin Laminate) - Chairside	[$86]	[$115]	[$144]
2960 – Covered only when the tooth cannot be restored by a composite resin filling, and then only if more than 5 years have elapsed since last placement.				
6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614	Inlay/Onlay - Two Surfaces	[$150]	[$200]	[$250]
6601, 6603, 6605, 6607, 6609, 6611, 6613, 6615	Inlay/Onlay - Three or More Surfaces	[$162]	[$216]	[$270]
6545	Cast Metal Retainer for Resin-Bonded Bridge	[$75]	[$101]	[$126]
6545 – Benefits for the replacement of an existing resin-bonded bridge is payable only if the existing resin-bonded bridge is more than 5 years old, is not serviceable, and cannot be repaired. Benefits for resin-bonded bridge pontics are based on the customary fee for base metal substrates. Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
6720	Crown - Resin with High Noble Metal	[$129]	[$173]	[$216]
6721	Crown - Resin with Predominantly Base Metal	[$129]	[$173]	[$216]
6722	Crown - Resin with Noble Metal	[$129]	[$173]	[$216]
6750	Crown - Porcelain Fused to High Noble Metal	[$173]	[$230]	[$288]
6751	Crown - Porcelain Fused to Predominantly Base Metal	[$150]	[$200]	[$250]
6752	Crown - Porcelain Fused to Noble Metal	[$150]	[$200]	[$250]
6780	Crown - ¾ Cast High Noble Metal	[$150]	[$200]	[$250]
6781	Crown – ¾ Cast Predominantly Base Metal	[$150]	[$200]	[$250]
6782	Crown – ¾ Cast Noble Metal	[$150]	[$200]	[$250]
6790	Crown - Full Cast High Noble Metal	[$150]	[$200]	[$250]
6791	Crown - Full Cast Predominantly Base Metal	[$150]	[$200]	[$250]
6792	Crown - Full Cast Noble Metal	[$150]	[$200]	[$250]
6720-6792 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a necessary extraction of an additional functioning natural tooth which was not an abutment to an existing denture or resin-bonded bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.				
Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
6970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	[$56]	[$75]	[$93]
6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	[$43]	[$58]	[$72]
6970-6972 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the bridge retainer on the same tooth is also covered.				
6973	Core Build Up for Retainer, Including Any Pins	[$26]	[$35]	[$43]
6973 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the bridge retainer on the same tooth is also covered. Includes all pins and/or prefabricated posts.				
6210	Pontic - Cast High Noble Metal	[$131]	[$175]	[$219]
6211	Pontic - Cast Predominantly Base Metal	[$131]	[$175]	[$219]
6212	Pontic - Cast Noble Metal	[$131]	[$175]	[$219]
6240	Pontic - Porcelain Fused to High Noble Metal	[$150]	[$200]	[$250]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
6241	Pontic - Porcelain Fused to Predom. Base Metal	[$131]	[$175]	[$219]
6242	Pontic - Porcelain Fused to Noble Metal	[$131]	[$175]	[$219]
6250	Pontic - Resin with High Noble Metal	[$131]	[$175]	[$219]
6251	Pontic - Resin with Predominantly Base Metal	[$131]	[$175]	[$219]
6252	Pontic - Resin with Noble Metal	[$131]	[$175]	[$219]
6210-6252 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a Necessary extraction of an additional functioning natural tooth which was not an abutment to an existing denture or resin-bonded bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.				
Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
0470	Diagnostic Casts	[$11]	[$14]	[$18]
0470 – Not covered for orthodontic evaluation. Limited to one time in any 36 consecutive month period and only if diagnostic casts are required for extensive bilateral prosthetic dentistry other than dentures.				
5110	Complete Denture - Maxillary	[$206]	[$275]	[$344]
5120	Complete Denture - Mandibular	[$206]	[$275]	[$344]
5130	Immediate Denture - Maxillary	[$206]	[$275]	[$344]
5140	Immediate Denture - Mandibular	[$206]	[$275]	[$344]
5110-5140 – There are no additional benefits for personalized dentures or for overdentures and associated procedures. Limited to one denture per arch per 5 years.				
5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[$150]	[$200]	[$250]
5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[$150]	[$200]	[$250]
5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including ar conventional clasps, rests and teeth)	[$206]	[$275]	[$344]
5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including ar conventional clasps, rests and teeth)	[$206]	[$275]	[$344]
5211-5214 – There are no additional benefits for precision or semi-precision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Limited to one partial denture per arch per 5 years unless there is a necessary extraction of an additional functioning natural tooth.				
4210	Gingivectomy or Gingivoplasty – Four or More Teeth Per Quadrant	[$60]	[$81]	[$101]
4211	Gingivectomy or Gingivoplasty – One to Three Teeth Per Quadrant	[$22]	[$29]	[$36]
4240	Gingival Flap Procedure, Including Root Planing - Four or More Teeth Per Quadrant	[$86]	[$115]	[$144]
4241	Gingival Flap Procedure, Including Root Planing - One to Three Teeth Per Quadrant	[$70]	[$58]	[$72]
4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Teeth Per Quadrant	[$220]	[$216]	[$270]
4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Teeth Per Quadrant	[$160]	[$109]	[$137]
4210-4261 – Only one periodontal surgical procedure is covered per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion which requires treatment. Includes local anesthesia and routine post-operative care.				
4263	Bone Replacement Graft - 1st Site in Quadrant	[$60]	[$81]	[$101]
4264	Bone Replacement Graft - Each Additional Site in Quadrant	[$30]	[$40]	[$50]
4263-4264 – Includes local anesthesia and routine post-operative care.				
4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	[$69]	[$92]	[$115]
4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	[$78]	[$104]	[$129]
4266-4267 – Only one periodontal surgical procedure is covered per area of the mouth in any 36 consecutive month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery. Includes local anesthesia and routine post-operative care.				
4270	Pedicle Soft Tissue Graft Procedure	[$108]	[$144]	[$180]
4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[$119]	[$158]	[$198]
4273	Subepithelial Connective Tissue Graft Procedures	[$129]	[$173]	[$216]
4274	Distal or Proximal Wedge Procedure	[$47]	[$63]	[$79]
4270-4274 – Includes local anesthesia and routine post-operative care. Includes local anesthesia and routine post-operative care.				
4274 – Not payable on same date as codes 4260, 4261.				

LIST OF COVERED DENTAL SERVICES - ENHANCED PLAN

The following is a complete list of those dental services which will be considered for payment by the Company after the expiration of any applicable waiting period. These services must be started while insured and completed while insured or during the extension of benefits period, if any.

No payment will be made for any expense or for any service not included in the list if covered dental services or included in the list of exclusions.

Type I Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
0120	Periodic Oral Evaluation	[$20]	[$26]	[$33]
0150	Comprehensive Oral Evaluation	[$30]	[$40]	[$50]
0120, 0150 – Limited to one time in any 6 consecutive month period.				
1110	Prophylaxis - Adult	[$45]	[$60]	[$75]
1110 – Limited to one time in any 180 consecutive day period. This frequency limit is combined with the 180 day frequency limit for periodontal maintenance (code 4910). Only one occurrence of either procedure is payable in any 180 consecutive day period.				

Type II Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
0210	Intraoral - Complete Series (inc bitewings)	[$51]	[$68]	[$84]
0330	Panoramic Film	[$38]	[$50]	[$63]
0210, 0330 – Limited to one time in any 60 consecutive month period. For benefit determination purposes, a full mouth series will be deemed to include bitewings and 10 or more periapical x-rays.				
0220	Intraoral - Periapical - First Film	[$8]	[$11]	[$14]
0230	Intraoral - Periapical - Each Addl Film	[$4]	[$5]	[$6]
0220-0230 – A maximum of 4 periapical x-rays are payable per 12 month period.				
0240	Intraoral - Occlusal Film	[$14]	[$18]	[$23]
0240 – Limited to two films in any 12 consecutive month period.				
0270	Bitewing - Single Film	[$9]	[$12]	[$15]
0272	Bitewings - Two Films	[$15]	[$20]	[$25]
0274	Bitewings - Four Films	[$23]	[$30]	[$38]
0270-0274 – Limited to one set in any 12 consecutive month period. Reimbursement will be limited to a maximum of 4 films per occurrence.				
2140	Amalgam - One Surface	[$45]	[$60]	[$75]
2150	Amalgam - Two Surfaces	[$56]	[$75]	[$94]
2160	Amalgam - Three Surfaces	[$68]	[$90]	[$113]
2161	Amalgam - Four or More Surfaces	[$79]	[$105]	[$131]
2140-2161 – Multiple restorations on one surface will be paid as a single filling. Benefits for the replacement of an existing amalgam restoration are only payable if at least 24 months have passed since the existing amalgam was placed.				
2330	Resin-based Composite - One Surface, Anterior	[$56]	[$75]	[$94]
2331	Resin-based Composite - Two Surfaces, Anterior	[$68]	[$90]	[$113]
2332	Resin-based Composite - Three Surfaces, Anterior	[$79]	[$105]	[$131]
2335	Resin-based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	[$90]	[$120]	[$150]
2391	Resin-based Composite - One Surface, Posterior	[$45]	[$60]	[$75]
2392	Resin-based Composite - Two Surfaces, Posterior	[$56]	[$75]	[$94]
2393	Resin-based Composite - Three Surfaces, Posterior	[$68]	[$90]	[$113]
2394	Resin-based Composite - Four or More Surfaces, Posterior	[$79]	[$105]	[$131]
2330-2394 – Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations. Benefits for the replacement of an existing composite resin restoration are only payable if at least 24 months have passed since the existing filling was placed. Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.				

Type II Dental Services (continued) **Enhanced Plan**

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
7140	SIMPLE EXTRACTION Root Removal - Exposed Roots	[$50]	[$70]	[$85]
7140 – The benefit includes an allowance for local anesthesia and routine post-operative care.				
9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	[$28]	[$38]	[$47]
9110 – Paid as a separate benefit only if no other service is rendered during the visit except x-rays.				
0415	Bacteriologic Studies for Determination of Pathologic Agents	[$45]	[$60]	[$75]
0415 – Only payable in conjunction with a covered biopsy procedure (codes 7285, 7286).				
5410	Adjust Complete Denture - Maxillary	[$30]	[$40]	[$50]
5411	Adjust Complete Denture - Mandibular	[$30]	[$40]	[$50]
5421	Adjust Partial Denture - Maxillary	[$30]	[$40]	[$50]
5422	Adjust Partial Denture - Mandibular	[$30]	[$40]	[$50]
5410-5422 – Only covered one time in any 12 consecutive month period, and only if performed more than 12 months after the initial insertion of the denture.				
5510	Repair Broken Complete Denture Base	[$56]	[$75]	[$94]
5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	[$51]	[$68]	[$84]
5610	Repair Resin Denture Base	[$62]	[$83]	[$103]
5620	Repair Cast Framework	[$68]	[$90]	[$113]
5630	Repair or Replace Broken Clasp	[$68]	[$90]	[$113]
5640	Replace Broken Teeth - Per Tooth	[$56]	[$75]	[$94]
5650	Add Tooth to Existing Partial Denture	[$68]	[$90]	[$113]
5660	Add Clasp to Existing Partial Denture	[$79]	[$105]	[$131]
5510-5660 – Limited to repairs performed more than 12 months after initial insertion of the denture and then not more frequently than once per denture in any 12 consecutive month period.				
2910	Recement Inlay	[$34]	[$45]	[$56]
2920	Recement Crown	[$34]	[$45]	[$56]
2910-2920 – Payable only when performed more than 12 months after initial insertion.				
6930	Recement Fixed Partial Denture	[$51]	[$68]	[$84]
6930 – Payable only when performed more than 12 months after initial insertion of the denture.				
7285	Biopsy of Oral Tissue - Hard (Bone,Tooth)	[$225]	[$300]	[$375]
7286	Biopsy of Oral Tissue - Soft (All Others)	[$141]	[$188]	[$234]
7285-7286 – The benefit includes an allowance for local anesthesia and routine post-operative care.				

Type III Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
3310	Anterior (Excluding Final Restoration)	[$170]	[$225]	[$280]
3320	Bicuspid (Excluding Final Restoration)	[$200]	[$265]	[$330]
3330	Molar (Excluding Final Restoration)	[$250]	[$330]	[$415]
3310-3330 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up ca Payable once per tooth in any 36 consecutive month period.				
3346	Retreatment of Previous Root Canal Therapy - Anterior	[$170]	[$225]	[$280]
3347	Retreatment of Previous Root Canal Therapy - Bicuspid	[$200]	[$265]	[$330]
3348	Retreatment of Previous Root Canal Therapy - Molar	[$250]	[$330]	[$415]
3346-3348 – Subject to review by our dental consultant. Only payable if the original root canal procedure was performed at least 36 months earlier.				
3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Ro Resorption, etc.)	[$53]	[$70]	[$88]
3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repa of Perforations, Root Resorption, etc.)	[$35]	[$47]	[$59]
3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apic Closure/Calcific Repair of Perforations, Root Resorption, etc.)	[$141]	[$188]	[$234]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
3410	Apicoectomy/Periradicular Surgery - Anterior	[$123]	[$164]	[$205]
3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	[$158]	[$211]	[$264]
3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	[$176]	[$234]	[$293]
3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	[$53]	[$70]	[$88]
3351-3426 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up ca Payable once per tooth in any 36 consecutive month period.				
3430	Retrograde Filling - Per Root	[$42]	[$56]	[$70]
3430 – Includes all pre-operative, operative and post-operative x-rays, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.				
3450	Root Amputation - Per Root	[$105]	[$141]	[$176]
3920	Hemisection (Including Any Root Removal), Not Incl. Root Canal Therapy	[$84]	[$113]	[$141]
3450-3920 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.				
5710	Rebase Complete Maxillary Denture	[$120]	[$160]	[$200]
5711	Rebase Complete Mandibular Denture	[$120]	[$160]	[$200]
5720	Rebase Maxillary Partial Denture	[$120]	[$160]	[$200]
5721	Rebase Mandibular Partial Denture	[$120]	[$160]	[$200]
5730	Reline Complete Maxillary Denture (Chairside)	[$63]	[$84]	[$105]
5731	Reline Complete Mandibular Denture (Chairside)	[$63]	[$84]	[$105]
5740	Reline Maxillary Partial Denture (Chairside)	[$63]	[$84]	[$105]
5741	Reline Mandibular Partial Denture (Chairside)	[$63]	[$84]	[$105]
5750	Reline Complete Maxillary Denture (Laboratory)	[$84]	[$113]	[$140]
5751	Reline Complete Mandibular Denture (Laboratory)	[$84]	[$113]	[$140]
5760	Reline Maxillary Partial Denture (Laboratory)	[$84]	[$113]	[$140]
5761	Reline Mandibular Partial Denture (Laboratory)	[$84]	[$113]	[$141]
5710-5761 – Limited to relining or rebasing done more than 12 months after the initial insertion, and then not more than one time per denture in any 36 consecutive month period.				
5850	Tissue Conditioning, Maxillary	[$28]	[$38]	[$47]
5851	Tissue Conditioning, Mandibular	[$28]	[$38]	[$47]
5850-5851 – Payable only if at least 12 months have elapsed since the insertion of a full or partial denture and only once in any 36 consecutive month period.				
4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant	[$42]	[$56]	[$70]
4342	Periodontal Scaling and Root Planing – One to Three Teeth Per Quadrant	[$21]	[$28]	[$35]
4341-4342 – Limited to one time per quadrant of the mouth in any 24 consecutive month period. Not separately payable if performed on the same treatment plan as prophylaxis.				
4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	[$28]	[$38]	[$47]
4355 – Payable once per patient per lifetime. Not payable if performed on same date as prophylaxis (code 1110).				
4910	Periodontal Maintenance	[$28]	[$38]	[$47]
4910 – Payable only if at least 6 months have passed since the completion of active periodontal surgery and only one time thereafter in any 6 consecutive month period. Not payable if performed within 6 months of a prophylaxis (code 1110). The benefit for this procedure includes an allowance for an exam and scaling and root planing.				
7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal Bone and/or Section of Tooth	[$56]	[$75]	[$94]
7220	Removal of Impacted Tooth - Soft Tissue	[$72]	[$96]	[$120]
7230	Removal of Impacted Tooth - Partially Bony	[$91]	[$122]	[$152]
7240	Removal of Impacted Tooth - Completely Bony	[$108]	[$144]	[$180]
7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	[$127]	[$169]	[$211]
7250	Surgical Removal of Residual Tooth Roots (cutting Procedure)	[$42]	[$56]	[$70]
7310	Alveoloplasty in Conjunction with Extractions - Per Quadrant	[$56]	[$75]	[$94]
7320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	[$123]	[$164]	[$205]
7471	Removal of Lateral Exostosis (Maxilla or Mandible)	[$105]	[$141]	[$176]
7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	[$53]	[$70]	[$88]
7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	[$53]	[$70]	[$88]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	[$113]	[$150]	[$188]
7970	Excision of Hyperplastic Tissue - Per Arch	[$98]	[$131]	[$164]
7971	Excision of Pericoronal Gingiva	[$42]	[$56]	[$70]
7210-7971 – The benefit includes an allowance for local anesthesia and routine post-operative care.				
9220	General Anesthesia - First 30 Minutes	[$70]	[$94]	[$117]
9221	General Anesthesia - Each Additional 15 Minutes	[$28]	[$38]	[$47]
9241	Intravenous Sedation – First 30 Min	[$56]	[$75]	[$94]
9242	Intravenous Sedation – Ea Add 15 Min	[$18]	[$23]	[$29]
9220-9241 – Paid as a separate benefit only when necessary, as determined by us, and when administered in conjunction with complex oral surgical procedures which are covered under the policy.				
9940	Occlusal Guard, By Report	[$123]	[$164]	[$205]
9940 – Limited to one appliance in any 24 consecutive month period.				
9951	Occlusal Adjustment, Limited	[$25]	[$33]	[$41]
9952	Occlusal Adjustment, Complete	[$88]	[$117]	[$146]
9951-9952 – Payable once in any 36 month period.				

Type IV Dental Services

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
2520	Inlay - Metallic - Two Surfaces	[$211]	[$281]	[$352]
2530	Inlay - Metallic - Three or More Surfaces	[$264]	[$352]	[$439]
2542	Onlay - Metallic - Two Surfaces	[$211]	[$281]	[$352]
2543	Onlay - Metallic - Three Surfaces	[$264]	[$352]	[$439]
2544	Onlay - Metallic - Four or More Surfaces	[$281]	[$375]	[$469]
2620	Inlay - Porcelain/ceramic - Two Surfaces	[$211]	[$281]	[$352]
2630	Inlay - Porcelain/ceramic - Three or More Surfaces	[$264]	[$352]	[$439]
2642	Onlay - Porcelain/ceramic - Two Surfaces	[$211]	[$281]	[$352]
2643	Onlay - Porcelain/ceramic - Three Surfaces	[$264]	[$352]	[$439]
2644	Onlay - Porcelain/ceramic - Four or More Surfaces	[$281]	[$375]	[$469]
2651	Inlay - Composite-Resin - Two Surfaces (Laboratory Processed)	[$211]	[$281]	[$352]
2652	Inlay - Composite-Resin - Three or More Surfaces (Laboratory Processed)	[$264]	[$352]	[$439]
2662	Onlay - Composite-Resin - Two Surfaces (Laboratory Processed)	[$211]	[$281]	[$352]
2663	Onlay - Composite-Resin - Three Surfaces (Laboratory Processed)	[$264]	[$352]	[$439]
2664	Onlay - Composite-Resin - Four or More Surfaces (Laboratory Processed)	[$281]	[$375]	[$469]
2520-2664 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit includes an allowance for any filling paid on the same tooth during the 90 day period preceding the preparation date of the inlay or onlay.				
2720	Crown - Resin with High Noble Metal	[$211]	[$281]	[$350]
2721	Crown - Resin w/ Predominantly Base Metal	[$211]	[$281]	[$350]
2722	Crown - Resin with Noble Metal	[$211]	[$281]	[$350]
2740	Crown - Porcelain/ceramic Substrate	[$258]	[$344]	[$430]
2750	Crown - Porcelain Fused to High Noble Metal	[$281]	[$375]	[$450]
2751	Crown - Porcelain Fused to Predominantly Base Metal	[$234]	[$313]	[$390]
2752	Crown - Porcelain Fused to Noble Metal	[$234]	[$313]	[$390]
2780	Crown – ¾ Cast High Noble Metal	[$234]	[$313]	[$390]
2781	Crown – ¾ Cast Predominantly Base Metal	[$234]	[$313]	[$390]
2782	Crown – ¾ Cast Noble Metal	[$234]	[$313]	[$390]
2790	Crown - Full Cast High Noble Metal	[$234]	[$313]	[$390]
2791	Crown - Full Cast Predominantly Base Metal	[$234]	[$313]	[$390]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
2792	Crown - Full Cast Noble Metal	[$234]	[$313]	[$390]
2720-2792 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit for a crown includes an allowance for any filling paid on the same tooth in the 90 day period preceding the preparation date of the crown.				
2950	Core Buildup, including any Pins	[$42]	[$56]	[$70]
2950 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the crown, inlay or onlay on the same tooth is covered. Includes all pins and/or prefabricated posts.				
2952	Cast Post and Core in Addition to Crown	[$91]	[$122]	[$152]
2954	Prefabricated Post and Core in Addition to Crown	[$70]	[$94]	[$117]
2952-2954 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the crown, inlay or onlay on the same tooth is covered.				
2960	Labial Veneer (Resin Laminate) - Chairside	[$141]	[$188]	[$234]
2960 – Covered only when the tooth cannot be restored by a composite resin filling, and then only if more than 5 years have elapsed since last placement.				
6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614	Inlay/Onlay - Two Surfaces	[$246]	[$328]	[$410]
6601, 6603, 6605, 6607, 6609, 6611, 6613, 6615	Inlay/Onlay - Three or More Surfaces	[$264]	[$352]	[$439]
6545	Cast Metal Retainer for Resin-Bonded Bridge	[$123]	[$164]	[$205]
6545 – Benefits for the replacement of an existing resin-bonded bridge is payable only if the existing resin-bonded bridge is more than 5 years old, is not serviceable, and cannot be repaired. Benefits for resin-bonded bridge pontics are based on the customary fee for base metal substrates. Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
6720	Crown - Resin with High Noble Metal	[$211]	[$281]	[$352]
6721	Crown - Resin with Predominantly Base Metal	[$211]	[$281]	[$352]
6722	Crown - Resin with Noble Metal	[$211]	[$281]	[$352]
6750	Crown - Porcelain Fused to High Noble Metal	[$281]	[$375]	[$469]
6751	Crown - Porcelain Fused to Predominantly Base Metal	[$235]	[$310]	[$390]
6752	Crown - Porcelain Fused to Noble Metal	[$235]	[$310]	[$390]
6780	Crown - ¾ Cast High Noble Metal	[$235]	[$310]	[$390]
6781	Crown – ¾ Cast Predominantly Base Metal	[$235]	[$310]	[$390]
6782	Crown – ¾ Cast Noble Metal	[$235]	[$310]	[$390]
6790	Crown - Full Cast High Noble Metal	[$235]	[$310]	[$390]
6791	Crown - Full Cast Predominantly Base Metal	[$235]	[$310]	[$390]
6792	Crown - Full Cast Noble Metal	[$235]	[$310]	[$390]
6720-6792 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a necessary extraction of an additional functioning natural tooth which was not an abutment to an existing denture or resin-bonded bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.				
Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
6970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	[$91]	[$122]	[$152]
6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	[$70]	[$94]	[$117]
6970-6972 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the bridge retainer on the same tooth is also covered.				
6973	Core Build Up for Retainer, Including Any Pins	[$42]	[$56]	[$70]
6973 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the bridge retainer on the same tooth is also covered. Includes all pins and/or prefabricated posts.				
6210	Pontic - Cast High Noble Metal	[$235]	[$310]	[$390]
6211	Pontic - Cast Predominantly Base Metal	[$235]	[$310]	[$390]
6212	Pontic - Cast Noble Metal	[$235]	[$310]	[$390]
6240	Pontic - Porcelain Fused to High Noble Metal	[$235]	[$310]	[$390]

CDT-4 Procedure Code	Description of Service	Benefit Amount		
		Area A	Area B	Area C
6241	Pontic - Porcelain Fused to Predom. Base Metal	[$235]	[$310]	[$390]
6242	Pontic - Porcelain Fused to Noble Metal	[$235]	[$310]	[$390]
6250	Pontic - Resin with High Noble Metal	[$210]	[$280]	[$350]
6251	Pontic - Resin with Predominantly Base Metal	[$210]	[$280]	[$350]
6252	Pontic - Resin with Noble Metal	[$210]	[$280]	[$350]
6210-6252 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a necessary extraction of an additional functioning natural tooth which was not an abutment to an existing denture or resin-bonded bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.				
Fixed bridges (including resin-bonded bridges) that consist of multiple contiguous units are deemed to be a single bridge for benefit determination. The expense for a fixed bridge is deemed incurred in the policy year when the bridge was cemented permanently in the mouth.				
0470	Diagnostic Casts	[$18]	[$23]	[$29]
0470 – Not covered for orthodontic evaluation. Limited to one time in any 36 consecutive month period and only if diagnostic casts are required for extensive bilateral prosthetic dentistry other than dentures.				
5110	Complete Denture - Maxillary	[$338]	[$450]	[$563]
5120	Complete Denture - Mandibular	[$338]	[$450]	[$563]
5130	Immediate Denture - Maxillary	[$338]	[$450]	[$563]
5140	Immediate Denture - Mandibular	[$338]	[$450]	[$563]
5110-5140 – There are no additional benefits for personalized dentures or for overdentures and associated procedures. Limited to one denture per arch per 5 years.				
5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[$246]	[$328]	[$410]
5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[$246]	[$328]	[$410]
5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including ar conventional clasps, rests and teeth)	[$350]	[$470]	[$575]
5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including ar conventional clasps, rests and teeth)	[$350]	[$470]	[$575]
5211-5214 – There are no additional benefits for precision or semi-precision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Limited to one partial denture per arch per 5 years unless there is a necessary extraction of an additional functioning natural tooth.				
4210	Gingivectomy or Gingivoplasty – Four or More Teeth Per Quadrant	[$100]	[$130]	[$165]
4211	Gingivectomy or Gingivoplasty – One to Three Teeth Per Quadrant	[$35]	[$50]	[$65]
4240	Gingival Flap Procedure, Including Root Planing - Four or More Teeth Per Quadrant	[$141]	[$188]	[$234]
4241	Gingival Flap Procedure, Including Root Planing - One to Three Teeth Per Quadrant	[$70]	[$95]	[$120]
4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Teeth Per Quadrant	[$260]	[$350]	[$440]
4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Teeth Per Quadrant	[$190]	[$250]	[$310]
4210-4261 – Only one periodontal surgical procedure is covered per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion which requires treatment. Includes local anesthesia and routine post-operative care.				
4263	Bone Replacement Graft - 1st Site in Quadrant	[$98]	[$131]	[$164]
4264	Bone Replacement Graft - Each Additional Site in Quadrant	[$49]	[$66]	[$82]
4263-4264 – Includes local anesthesia and routine post-operative care.				
4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	[$113]	[$150]	[$188]
4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	[$127]	[$169]	[$211]
4266-4267 – Only one periodontal surgical procedure is covered per area of the mouth in any 36 consecutive month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery. Includes local anesthesia and routine post-operative care.				
4270	Pedicle Soft Tissue Graft Procedure	[$176]	[$234]	[$293]
4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	[$193]	[$258]	[$322]
4273	Subepithelial Connective Tissue Graft Procedures	[$211]	[$281]	[$352]
4274	Distal or Proximal Wedge Procedure	[$77]	[$103]	[$130]
4270-4274 – Includes local anesthesia and routine post-operative care. Includes local anesthesia and routine post-operative care.				
4274 – Not payable on same date as codes 4260, 4261.				

CONSIDERATION

We have issued this policy to you in consideration of your statements on the application, and payment of the first premium.

INSURING CLAUSE

We hereby insure you and your covered spouse against specified losses resulting from injury or sickness. We agree to pay the benefits described, subject to the definitions, provisions, limitations and exclusions of this policy.

TERMS OF COVERAGE

The term of this policy begins on the effective date shown in the policy schedule at 12:01am Standard time at the place you reside. The term will end, subject to the grace period, at 11:59pm Standard time on the date any renewal premium is due and unpaid. Premiums are payable directly to us or through our authorized agent. Premiums must be paid on or before the date they are due, subject to the grace period.

PART I: DEFINITIONS

These are some of the key words used in this policy. They are important in describing both your rights and ours.

INSURED PERSON means you and your covered spouse who is named in the application or subsequently added, and who is eligible under the terms of the Eligibility and Termination provision.

EFFECTIVE DATE means the date coverage is effective under this policy. The effective date is shown in the policy schedule. It is the date that determines the policy year and policy anniversary.

INJURY means accidental bodily injury sustained: directly and independently of disease or bodily infirmity or any other causes; and while this policy is in force.

NOTICE TO US means information we have received at our office which is written and signed by you.

OUR OFFICE means our administrative office, or any other office that we may choose for the purpose of administering this policy.

DENTIST means someone who is licensed to practice dentistry and is acting within the scope of their license. The term dentist shall also include the following healthcare professionals, providing the services performed are within the scope of the professional's license: dental hygienists, denturists, and physicians.

EMERGENCY TREATMENT means any necessary service rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

COVERED DENTAL SERVICE means a service that is included in the list of covered dental services in this policy. Covered dental services must be received while the insured person is covered under this policy, and the policy is in force.

SERVICE means a procedure or supply that is performed by a dentist in connection with the dental care of an insured person.

FUNCTIONING NATURAL TOOTH means a natural tooth which is performing its normal role in the mastication (chewing) process in the insured person's upper or lower arch. It must be opposed in the insured person's other arch by another natural tooth or prosthetic replacement. For the purposes of this policy, third molars are not considered functioning natural teeth.

TREATMENT PLAN means the dentist's report of recommended treatment in a form satisfactory to us. The treatment plan should:

1. itemize the services and charges provided or to be provided; and
2. include supporting pre-operative x-rays and any other diagnostic materials we may require.

WAITING PERIOD means a period of time beginning on the covered person's effective date, before benefits for certain services are payable. Waiting periods vary by type of service and are listed in the policy's schedule of benefits.

DEDUCTIBLE means the amount of covered dental service which must be paid by you each policy year for each insured person, before we pay any benefits under this policy. The deductible is listed in the policy's schedule of benefits.

ANNUAL MAXIMUM means the maximum benefit we will pay for covered dental services completed in a policy year. The annual maximum is listed in the policy's schedule of benefits.

DATE STARTED means the date on which certain covered dental services will be considered started. These services and corresponding dates are shown here:

1. Full or partial dentures: the date the final impression is taken.
2. Fixed bridges, crowns, inlays, onlays and other laboratory prepared restorations: the date the teeth are first prepared or drilled down to receive the restoration.
3. Root canal therapy: the date the pulp chamber is first opened.
4. Periodontal surgery: the date the surgery is performed.
5. All other services: the date the service is performed.

No benefit is payable for any covered dental service which is started prior to an insured person's effective date, or during the waiting period for that service.

DATE COMPLETED means the date on which certain covered dental services will be considered completed. These services and corresponding dates are shown here:

1. Full or partial dentures: the date the final completed appliance is first inserted into the mouth, and has been accepted by the insured person.
2. Fixed bridges, crowns, inlays, onlays and other laboratory prepared restorations: the date the restoration is permanently cemented in place.
3. Root canal therapy: the date the canals are permanently filled.

For benefit payment purposes, the date completed will be considered the date when a covered dental expense is incurred.

PART II: ELIGIBILITY AND TERMINATION

ELIGIBILITY. You and your covered spouse are eligible for coverage under this policy. You must be at least 63 years of age and a legal resident of the United States. Your spouse is also eligible, irrespective of your spouse's age.

If you have no spouse when you are first covered under this policy but later marry, you may apply to have your spouse added to your policy. You can do this by making a written request to us. You must make this request within 60 days of the date you marry. Your spouse's coverage will then become effective on the date shown in the amendment to the policy that we will send you.

TERMINATION. Your coverage will terminate at 11:59pm on the earlier of the following dates: the date you request; or the date your coverage lapses, subject to the grace period provision, if you fail to pay premiums when due.

Coverage for your spouse will terminate at 11:59pm on the earliest of the following dates: the date you request; the date your coverage lapses, subject to the grace period provision, if you fail to pay premiums when due; the next premium due date following the date of your divorce or annulment; or the date of your spouse's death.

PART III: EXCLUSIONS AND LIMITATIONS

This policy does not cover any loss listed below:

1. Services which are not included in the list of covered dental services in the policy schedule.
2. Services which are not necessary services, or for which a charge would not have been made in the absence of insurance.
3. Any service which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least 3 years, as we may determine.
4. Crowns, inlays, cast restorations or other laboratory prepared restorations on teeth which may be satisfactorily restored with an amalgam or resin-based composite filling.
5. Appliances, inlays, cast restorations, crowns or other laboratory prepared restorations used primarily for the purpose of splinting.
6. Any service or appliance used to change or maintain vertical dimension, alter or restore occlusion, bite registration or bite analysis.
7. Any services provided primarily for cosmetic purposes. Facings on crowns or bridge units on molars and composite resin restorations on molars are always considered cosmetic, for the purposes of this policy.
8. The initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the covered person is insured under this Policy.
9. The initial placement of a fixed bridge including a resin-bonded bridge, unless it includes the replacement of a functioning natural tooth extracted while the covered person is insured under this Policy. The tooth must not be an abutment to an existing partial denture or resin-bonded bridge less than 5 years old or to an existing fixed bridge less than 7 years old. Benefits are payable only for the replacement of those teeth which are extracted while the covered person was insured under the Policy.

10. Replacement of a partial denture, full denture, or fixed bridge (including a resin-bonded bridge) or the addition of teeth to a partial denture unless:
    a. Replacement occurs at least 5 years after the initial date of insertion of the current full or partial denture or resin-bonded bridge; or
    b. Replacement occurs at least 7 years after the initial date of insertion of an existing fixed bridge; or
    c. The replacement prosthesis or the addition of a tooth to a partial denture is required by the extraction of a functioning natural tooth while the covered person is insured under the policy. The tooth must not be an abutment to an existing partial denture or resin-bonded bridge less than 5 years old or to an existing fixed bridge less than 7 years old. Any extraction that qualifies as a prosthetic for benefit under this provision must be considered a necessary service.
11. Replacing crowns, cast restorations, inlays, onlays or other laboratory prepared restorations within 7 years of the date of insertion; or the replacement of a labial veneer restoration within 5 years of the date of insertion.
12. Replacing a bridge, partial denture, full denture, crown, cast restoration, inlay, onlay or other laboratory prepared restoration which can be repaired.
13. The replacement of teeth beyond the normal complement of 32.
14. Implants, charges for the insertion of implants and/or related appliances, or the surgical removal of implants.
15. Replacing an existing partial denture with fixed bridgework unless upgrading to fixed bridgework is essential to the correction of the covered person’s dental condition.
16. Athletic mouth guards, myofunctional therapy, infection control, precision or semi-precision attachments, denture duplication, oral hygiene instruction, separate charges for acid etch, broken appointments, treatment of jaw fractures, orthognathic surgery, completion of claim forms, exams required by a third party other than us, personal dental hygiene supplies (such as Water Pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances.
17. Charges for travel time, transportation costs, or professional advice given on the telephone.
18. Orthodontic treatment.
19. Services performed by a dentist who is member of the covered person’s family. The covered person’s family is limited to a spouse, siblings, children, grandchildren, and the spouse's siblings, children and grandchildren.
20. Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
21. Any service required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures.
22. Any charge for a Service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of $100 per Policy Year.
23. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared), taking part in an insurrection or riot, the commission or attempted commission of a crime, an intentionally self-inflicted injury or attempted suicide while sane or insane.

24. Any charge for a service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if the covered person did not purchase the coverage that is available to them.
25. Any service for which the covered person is not required to pay unless the payment of benefits is mandated by law and then only to the extent required by law.

PART IV: GENERAL CONTRACT PROVISIONS

ENTIRE CONTRACT/CHANGES. This policy, along with the application and any attached endorsements or riders or amendments of any kind, constitutes the entire contract between you and us. No change in this policy will be effective until approved by one of our executive officers. This approval must be in writing and noted on or attached to this policy. We will require your written consent before making any change that will reduce or eliminate benefits under this policy. No agent may change this policy or waive any of its provisions.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the due date, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the premium is not paid within the grace period, the policy will end.

REINSTATEMENT. We may reinstate your policy if it lapsed due to non-payment of premium. You must make a written application to us within sixty (60) days of the date your policy terminated. You will need to pay all premiums then due and unpaid, including the premium for the grace period. We will then reinstate the coverage under the policy back to the date it terminated as if no lapse in coverage had occurred.

THIRD PARTY PREMIUM NOTICE. When you apply for coverage, you may name another person other than your spouse for us to contact in the event you do not pay any premium that becomes due. We will only contact the person you designated if you are late in making a premium payment that is due and only to ensure that your policy does not lapse accidentally due to non-payment of premium.

LEGAL ACTION. No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

MISSTATEMENT OF AGE. If the age of a covered person has been misstated in the application, the benefits will be those the premium paid would have purchased at the correct age.

NON-PARTICIPATING. This policy will not share in our surplus earnings.

CONFORMITY WITH STATE STATUTES. On the effective date, any provision of this policy which is in conflict with the statutes of the state where you reside is amended to conform to the minimum requirements of those statutes.

UNPAID PREMIUMS. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

CONTESTABILITY. This policy is not contestable.

UNEARNED PREMIUMS. We will refund any unearned premium paid for an insured who dies while this policy is in force. This refund will be paid in a lump sum no later than 30 days after we receive proof of death of the insured.

PART V: CLAIM PROVISIONS

NOTICE OF CLAIM. You must give us written notice of a claim within 90 days of the date of a covered loss. We will not deny a claim filed after 90 days from the date of loss if the claim is filed as soon as reasonably possible, or it was not reasonably possible to file the claim within 90 days. In any event, the claim must be filed within one year after the end of the 90 day period, unless you had no legal capacity to file the claim.

CLAIM FORM. You may request forms from us, or you may use standard ADA-approved claim forms supplied by your dentist. The claim form is considered a proof of loss, for the purposes of this section.

PROOF OF LOSS. Proof of loss must include the dentist's statement of treatment received.

TIME OF PAYMENT OF CLAIMS. Benefits for covered expenses under this policy will be paid promptly. We will pay benefits directly to you, unless you assign benefits to your dentist.

PRE-ESTIMATION OF BENEFITS. When the estimated cost of a recommended dental treatment plan exceeds $300, the treatment plan must be submitted to us for review before treatment begins. The treatment plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that we request.

We will notify the insured person and the dentist of the estimated benefits payable based upon the treatment plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If the insured person and dentist decide on a more expensive method of treatment than we pre-estimate, benefits will be paid for the more costly treatment, but only up to the policy maximum for the less expensive alternate service. We will not pay the excess amount.

ALTERNATE BENEFITS. There is often more than one service that can be used to treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. The amount payable will be limited to the least costly service which meets broadly accepted standards of dental care as we determine. The insured person and dentist may decide on a more costly procedure or material than we have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material. Payment will be limited to the covered dental expense subject to the deductible for the least costly service. We will not pay the excess amount.

EXTENSION OF BENEFITS. If a covered dental service is started while coverage is in effect for an insured person but is completed after the termination date, we will pay benefits for otherwise covered dental services subject to all of the following:

a. Benefits are not available for any service started after you or your covered spouse's insurance ends;

b. Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, if the insurance for you or your spouse were still in effect;

c. Benefits are payable only if the service is completed within thirty (30) days after the date you or your spouse's insurance ends, unless you or your spouse becomes injured or sick after the service is started and could not complete the service during those thirty (30) days. Then, benefits are payable only if the service is completed before the earlier of:

   i. thirty (30) days after the first date the injury or sickness no longer prevents the service from being completed; or

   ii. ninety (90) days after the date on which you or your spouse's insurance ends.

BENEFITS FOR TEMPORARY SERVICES. A temporary dental service will be considered an integral part of the final dental service rather than as a separate service. The combined benefit payable for a temporary service and the final dental service is limited to the maximum benefit payable for the final dental service.

DENTAL PROOF OF LOSS. We have the right to require additional information to aid in the determination of benefits payable under this policy. The additional information required includes, but is not limited to, the following:

1. A complete dental charting showing extractions, missing teeth, fillings, prostheses, periodontal pocket depths and the date of any work previously performed.
2. An itemized bill for all dental care.
3. Pre-operative X-rays, study models, laboratory and/or hospital reports.
4. Physical examination of any insured person at our expense.

With the exception of a physical examination we request, any additional cost associated with providing satisfactory proof of loss to us under this provision is your responsibility.

REVIEW OF DENIED CLAIM. If we deny you or your spouse's claim in whole or in part, you may submit a written appeal to us. We will provide you a written decision within thirty (30) days after receipt of your appeal, unless special circumstances exist which require additional time. In the event we require additional time to consider your appeal, we will provide our written decision as soon as possible.

RIGHT OF RECOVERY (SUBROGATION). If you or your covered spouse has a claim for damages or a right to recover damages from a third party or parties for an injury for which benefits would be payable under this policy, we may have a right of recovery. Our right of recovery will be limited to any benefits we paid for your or your covered spouse's injuries under this policy, but not to include non-dental care or services. Any amounts received for future dental care or pain and suffering may not be recovered. Our right of recovery includes any compromise settlements. You or your attorney must notify us of any legal action or settlement agreement at least 10 days prior to settlement or trial. We will then advise you of the amount we would seek to recover for any benefits we paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and the expenses of litigation.

HOME OFFICE: Houston, Texas
ADMINISTRATIVE OFFICE:
PO Box 13667; Pensacola, FL 32591-3667
(866) 216-5844

LIMITED BENEFIT DENTAL INSURANCE POLICY
THIS POLICY CONTAINS A DEDUCTIBLE PROVISION
GUARANTEED RENEWABLE FOR LIFE
NON-PARTICIPATING

CONSTITUTION LIFE INSURANCE COMPANY

HOME OFFICE: Houston, Texas
ADMINISTRATIVE OFFICE:
PO Box 13667; Pensacola, FL 32591-3667
(866) 216-5844

LIMITED BENEFIT HEALTH INSURANCE COVERAGE
DENTAL INSURANCE

OUTLINE OF COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you **READ YOUR POLICY CAREFULLY**.

Limited Benefit Health Coverage – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

Annual Deductible, Per Person, Per Year	$ 0
Annual Maximum, Per Person, Per Year (Enhanced Benefit Plan)	$6,000
Annual Maximum, Per Person, Per Year (Standard Benefit Plan)	$1,500

Waiting Periods

Type I Services	None
Type II Services	6 Months
Type III Services	12 Months
Type IV Services	18 Months

Frequency Limits – Refer to Policy – Exclusions and Limitations

Only individuals age 63 and over are eligible for coverage. Spouses of covered persons are also eligible regardless of age. This policy is guaranteed renewable and subject to premium rate changes by class based on the state where the insured resided at the time the policy was issued.

CONSTITUTION LIFE INSURANCE COMPANY

HOME OFFICE: Houston, Texas
ADMINISTRATIVE OFFICE:
PO Box 13667; Pensacola, FL 32591-3667
(866) 216-5844

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Limited Benefit Health Coverage – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

Annual Deductible, Per Person, Per Year	$ 50
Annual Maximum, Per Person, Per Year (Enhanced Benefit Plan)	$6,000
Annual Maximum, Per Person, Per Year (Standard Benefit Plan)	$1,500

Waiting Periods

Type I Services	None
Type II Services	6 Months
Type III Services	12 Months
Type IV Services	18 Months

Frequency Limits – Refer to Policy – Exclusions and Limitations

Only individuals age 63 and over are eligible for coverage. Spouses of covered persons are also eligible regardless of age. This policy is guaranteed renewable and subject to premium rate changes by class based on the state where the insured resided at the time the policy was issued.

CONSTITUTION LIFE INSURANCE COMPANY

HOME OFFICE: Houston, Texas **ADMINISTRATIVE OFFICE**: P.O. Box 13547 - Pensacola, Florida 32591-3547

APPLICATION FOR SENIOR DENTAL INSURANCE

Area Factors ☐ A ☐ B ☐ C

Plan Deductible: $0

Benefit ☐ Enhanced ☐ Standard

PRIMARY INSURED NAME

LAST | FIRST | MI | SOCIAL SECURITY NUMBER

ADDRESS (Street/Rural Route)

ADDRESS (Line 2)

CITY | STATE | ZIP CODE | COUNTY

AGE | BIRTHDATE (MMDDYYYY) | SEX

SPOUSE TO BE INSURED

LAST | FIRST | MI | SOCIAL SECURITY NUMBER

AGE | BIRTHDATE (MMDDYYYY) | SEX

PREMIUM MODE

☐ **MONTHLY PAC or CREDIT CARD** ☐ **SEMI-ANNUAL** ☐ **ANNUAL**

Monthly premiums are only payable by automatic debits to either Your checking account or to Your Visa or MasterCard account. Semi-Annual and Annual premiums may be paid by either of these two methods or You may elect to have the Company mail you a bill for each Premium due.

PREMIUM PAYMENT METHOD

☐ **ACH** ☐ **CREDIT CARD** ☐ **DIRECT BILL**

Checking Account # _____ (Be sure to attach a voided check)

Credit Card: ☐ Visa ☐ MasterCard

Name on Credit Card _____ Account # _____ Exp. Date _____

You must enclose a check for the first Premium payment along with this Application. The amount of the first Premium payment for the Premium Mode You have selected is: $ _____.

Please make Your check payable to the Company. Do not make it payable to the agent or leave the payee blank.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of insurance fraud.

I hereby apply to Constitution Life Insurance Company for a policy of dental insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete. I understand that this application shall not be binding upon the Company until approved by the Company and that the benefits provided by the Policy are exactly those that are described in the Policy.

I acknowledge receipt of an Outline of Coverage.

_____ _____

Signature of Applicant | Signature of Spouse (if insured)

_____

City | State | Date

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

_____ _____ _____% _____

Agent Printed Name | Signature of Licensed Agent | Agent Code

_____ _____ _____% _____

Agent Printed Name | Signature of Licensed Agent | Agent Code

Applicant Signed in: _____

CONSTITUTION LIFE INSURANCE COMPANY

HOME OFFICE: Houston, Texas **ADMINISTRATIVE OFFICE**: P.O. Box 13547 - Pensacola, Florida 32591-3547

APPLICATION FOR SENIOR DENTAL INSURANCE

Area Factors ☐ A ☐ B ☐ C

Plan Deductible: $50

Benefit ☐ Enhanced ☐ Standard

PRIMARY INSURED NAME

LAST | FIRST | MI | SOCIAL SECURITY NUMBER

ADDRESS (Street/Rural Route)

ADDRESS (Line 2)

CITY | STATE | ZIP CODE | COUNTY

AGE | BIRTHDATE (MMDDYYYY) | SEX

SPOUSE TO BE INSURED

LAST | FIRST | MI | SOCIAL SECURITY NUMBER

AGE | BIRTHDATE (MMDDYYYY) | SEX

PREMIUM MODE

☐ **MONTHLY PAC or CREDIT CARD** ☐ **SEMI-ANNUAL** ☐ **ANNUAL**

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Signature of Applicant | Signature of Spouse (if insured)

_____

City | State | Date

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_____ _____ _____% _____

Agent Printed Name | Signature of Licensed Agent | Agent Code

_____ _____ _____% _____

Agent Printed Name | Signature of Licensed Agent | Agent Code

Applicant Signed in: _____

SERFF Tracking Number:	*UNAM-126216304*	*State:*	*Arkansas*
Filing Company:	*Constitution Life Insurance Company*	*State Tracking Number:*	*43153*
Company Tracking Number:	*CLDEN 09*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Sr. Dental*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/17/2009

Comments:

Attachment:

Readability Cert -CLIC AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/17/2009

Comments:

included

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/17/2009

Comments:

included

READABILITY CERTIFICATION

Filing for: Constitution Life Insurance Company
1001 Heathrow Park Lane
Lake Mary, Florida 32746

FORM NO.	DESCRIPTION	TEST SCORE
CLDEN 09 AR	Senior Dental Insurance Policy	46.8
CLDEN1 09 OC AR	Outline of Coverage $0 deductible	40.3
CLDEN2 09 OC AR	Outline of Coverage $50 deductible	40.3
CLDENAPP1 09 AR	Application - $0 deductible	
CLDENAPP2 09 AR	Application - $50 deductible	

I certify that the Flesch Reading Ease Scores for the above form is true and correct.

Michelle Doherty Digitally signed by Michelle Doherty
DN: cn=Michelle Doherty, o, ou=Product Filing & Compliance, email=mdoherty@uafc.com, c=US
Date: 2009.07.06 14:46:18 -04'00'

July 6, 2009

Michelle Doherty
Vice President, Compliance